

CERTIFICATE OF DEATH

Reg. Dist. No. 2910

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>HURLOCK 09X2-2</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>A.</u> Last <u>BAKER</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/25/81</u>
9. AGE (In years last birthday) yrs. <u>76</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		12. KIND OF BUSINESS OR INDUSTRY <u> </u>	
13. FATHER'S NAME <u>JAMES P. FRANK BAKER</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Travers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs Grace Baker (wife)</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Hemopoiesis/coordination</u> DUE TO <u>Rupture of left ventricle</u> DUE TO <u>Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>2:45 P.M.</u> to <u>3:54 P.M.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 25</u> , and that death occurred at <u>3:54 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		DATE SIGNED <u>25 Aug 57</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town, State) <u>219 S. Washington St. Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/27/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		22d. LOCATION (City, town, or county) (State) <u>Hurlock Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Miller</u>		ADDRESS <u>101 N. Market</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>N. J. Nevein</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08868

CERTIFICATE OF DEATH

08879

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Hamilton</u> Middle <u>Edgar</u> Last <u>Balderson</u>		4. DATE OF DEATH <u>8/25/57</u> Month <u>8</u> Day <u>25</u> Year <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27, 1867</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Balderson</u>		14. MOTHER'S MAIDEN NAME <u>Virginie Richardson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>My James A. Balderson (son)</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recent & Old coronary occlusions</u> <u>420.1</u> -DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Calcific aortic stenosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Same</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. <u>19</u> P. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/25/57</u> , 19 <u>57</u> , to <u>8/25/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/25/57</u> , and that death occurred at <u>3:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>219 S. Washington St. Easton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		DATE SIGNED <u>25 Aug 57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		22b. DATE THEREOF <u>Aug 27 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oxford Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman</u>		ADDRESS <u>104 Easton Rd</u>	
24a. REC'D BY REGISTRAR <u>3/27/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newell</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1-1-57

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
COUNTY		STATE	
AGE		SEX	
RACE		RELIGION	
EDUCATION		OCCUPATION	
MARRIAGE		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

BUREAU V. 3

AUG 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08869

CERTIFICATE OF DEATH

Reg. Dist. No.

08880
270

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> x1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Easton Memorial Hosp.</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>Campbell</u> Last <u>Campbell</u>				4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 1 1862</u>	
9. AGE (In years birth day) <u>94</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Levin H. Campbell</u>				14. MOTHER'S MAIDEN NAME <u>Mary P. Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Nellie Shackard (widow)</u>				Address <u>Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> (c) <u>age (94 yrs)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intestinal obstruction 24 hrs. delayed surg.</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 hrs.</u> ? 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/17</u> , 19 <u>57</u> , to <u>8/18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/18</u> , 19 <u>57</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J.T.B. Ambler</u> M.D.				ADDRESS (Street, city or town, state) <u>Box 96 Easton Md.</u>			
PHYSICIAN'S NAME (Type) <u>J.T.B. Ambler</u>				DATE SIGNED <u>8/21/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Aug. 21, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Newman</u> ADDRESS <u>Easton Md.</u>				24a. REC'D BY REGISTRAR DATE <u>8/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>M.H. Nesbitt</u>	

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		MARRIAGE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DATE OF DEATH JUL 27 1957		TIME OF DEATH 11:00 AM	
PLACE OF BIRTH BALTIMORE, MARYLAND		DATE OF BIRTH JUL 27 1957	
NAME OF DECEASED JOHN DOE		SEX MALE	
RACE WHITE		OCCUPATION CLERK	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. SMITH		SIGNATURE OF REGISTRAR A. BROWN	
DATE OF SIGNATURE JUL 27 1957		DATE OF SIGNATURE JUL 27 1957	

RECEIVED
 JUN 27 1957
 BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08870

CERTIFICATE OF DEATH

Reg. Dist. No.

08881
296

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>Today</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u> 17x02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>R.</u> Last <u>Coursey</u>				4. DATE OF DEATH 8 Month 2 Day 1957			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 2, 1897</u> 39 yrs.		9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oyster packer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walker Coursey</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Tolson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Anne Coursey (Wife)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung, rt.</u> 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>9</u> p. m. Month, Day, Year 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 19, 1957</u> to <u>August 19, 1957</u> , that I last saw the deceased alive on <u>8/11/57</u> , and that death occurred at <u>5:36 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Santon Md.</u> DATE SIGNED <u>8-5-57</u>							
ACTUAL SIGNATURE <u>Arthur B. Cecil</u> M.D.				PHYSICIAN'S NAME (Type) <u>ARTHUR B. CECIL JR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 5, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>STEVENSVILLE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Langford</u> ADDRESS <u>CHURCH HILL, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>8/5/57</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Newkirk</u>	

JUN 15 1957

RECEIVED

08871

CERTIFICATE OF DEATH

Reg. Dist. No. 290

08882

1. PLACE OF DEATH a. COUNTY <u>ALBANY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>36 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>CHESTER 17x2.2</u>	
3. NAME OF DECEASED (Type or print) First <u>Naomi</u> Middle <u>MARIE</u> Last <u>CROUCH</u>		4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/21/15</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
13. FATHER'S NAME <u>Joseph Sparks</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Mason</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-20-0081</u>	
17. INFORMANT <u>Mr. Melvin Crouch Hunt</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericarditis</u> <u>539.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rupture of myocardium</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		DATE SIGNED <u>26 Aug 57</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>219 S. Westmyer St. Easton, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>8/28/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Crestwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Burt</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>8/28/57</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Neekes</u>	

RECEIVED

Reg. Dist. No. 290

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>00</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centre ville 17x2.2</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boo</u> Last <u>Dill</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 20, 1957</u>			
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Robert Dill, Jr</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Wellaughby</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-uterine 270x12 - 762.0</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>27th Aug 1957</u> , and that death occurred at <u>6 P.</u> M., from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>2195 W 25th 179th St. 21 Aug 57</u>					
PHYSICIAN'S NAME (Type) <u>F. C. H. Schmidt</u>				DATE SIGNED <u>21 Aug 57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesapeake</u>		22d. LOCATION (City, town, or county) (State) <u>Chesapeake Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner Patton 41 Patton Bldg</u>				ADDRESS <u>Chesapeake Md</u>		24a. REC'D BY REGISTRAR DATE <u>8/22/57</u>			
				24b. REGISTRAR'S SIGNATURE <u>N. H. Newlin</u>					

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
RACE		RELIGION		MARRIED		SINGLE		WIDOWED		DIVORCED		SEPARATED		OTHER	
EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		SIGNATURE OF PHYSICIAN		DATE	
SIGNATURE OF REGISTRAR		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF WITNESS		DATE	

RECEIVED
AUG 27 1957
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08873

CERTIFICATE OF DEATH

08884

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 EASTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		d. STREET ADDRESS 1 15 South Harrison St.	
3. NAME OF DECEASED (Type or print) First Bessie Middle Fluharty Last Fluharty		4. DATE OF DEATH Month 8 Day 28 Year 1957	
5. SEX Fe.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28 1884 73 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		9b. AGE (In years last birthday) 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred Burkett		14. MOTHER'S MAIDEN NAME FANNIE PERRY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr Carl Burkett broder	
17. INFORMANT Mr Carl Burkett broder		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X Apoplexy DUE TO (b) arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) lying cause lost.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948 , 19 8/28 , 19 57 , that I last saw the deceased alive on 8/28 , 19 57 , and that death occurred at 8:20 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE P E Cox		DATE SIGNED 8/30/57	
PHYSICIAN'S NAME (Type) P E Cox		ADDRESS (Street, city or town, state) Easton Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 30 1957	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		24a. REC'D BY REGISTRAR 8/30/57	
24b. REGISTRAR'S SIGNATURE T. H. Newnam			

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SEP 3 1957

BUREAU V. 2

FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE		MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON	
CASE NO. 100-100000		DEATH NO. 100-100000	
DATE OF DEATH 10-1-57		PLACE OF DEATH 100-100000	
AGE 100-100000		SEX 100-100000	
RACE 100-100000		RELIGION 100-100000	
MARRIED 100-100000		EDUCATION 100-100000	
OCCUPATION 100-100000		MILITARY SERVICE 100-100000	
PREVIOUS ILLNESS 100-100000		CAUSE OF DEATH 100-100000	
MANNER OF DEATH 100-100000		CERTIFICATE OF DEATH 100-100000	
SIGNATURE OF DECEASED 100-100000		SIGNATURE OF WITNESS 100-100000	
DATE OF SIGNATURE 100-100000		PLACE OF SIGNATURE 100-100000	
FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE		MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON	

08874

CERTIFICATE OF DEATH

Reg. Dist. No.

08885 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 TILGHMAN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERNEST</u> <u>FRAMPTON</u>		4. DATE OF DEATH Month Day Year <u>AUGUST</u> <u>25</u> 19 <u>57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/12/65</u>
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>VINCENT FRAMPTON</u>		14. MOTHER'S MAIDEN NAME <u>WILHEMINA MELVINE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs P. Eran Cox (Daughter)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary atherosclerosis</u> DUE TO (c) <u>generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/25</u> , 19 <u>46</u> , to <u>8/25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/25</u> , 19 <u>57</u> , and that death occurred at <u>3:46</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. E. Cox</u>		ADDRESS (Street, city or town, state) <u>Easton Md</u>	
PHYSICIAN'S NAME (Type) <u>P. E. Cox</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 28/57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>M. E. Tilghman</u>		22d. LOCATION (City, town, or county) (State) <u>Tilghman Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John L. Moore</u>		ADDRESS <u>Tilghman Md</u>	
24a. REC'D BY REGISTRAR <u>Aug 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs N. J. Henry</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Aug 25 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SURVIVAL OF OTHERS <i>None</i>	
16. SIGNATURE OF DECEASED <i>John J. Smith</i>		17. SIGNATURE OF WITNESSES <i>John J. Smith</i>		18. SIGNATURE OF DECEASED <i>John J. Smith</i>	
19. SIGNATURE OF DECEASED <i>John J. Smith</i>		20. SIGNATURE OF WITNESSES <i>John J. Smith</i>		21. SIGNATURE OF DECEASED <i>John J. Smith</i>	
22. SIGNATURE OF DECEASED <i>John J. Smith</i>		23. SIGNATURE OF WITNESSES <i>John J. Smith</i>		24. SIGNATURE OF DECEASED <i>John J. Smith</i>	
25. SIGNATURE OF DECEASED <i>John J. Smith</i>		26. SIGNATURE OF WITNESSES <i>John J. Smith</i>		27. SIGNATURE OF DECEASED <i>John J. Smith</i>	
28. SIGNATURE OF DECEASED <i>John J. Smith</i>		29. SIGNATURE OF WITNESSES <i>John J. Smith</i>		30. SIGNATURE OF DECEASED <i>John J. Smith</i>	
31. SIGNATURE OF DECEASED <i>John J. Smith</i>		32. SIGNATURE OF WITNESSES <i>John J. Smith</i>		33. SIGNATURE OF DECEASED <i>John J. Smith</i>	
34. SIGNATURE OF DECEASED <i>John J. Smith</i>		35. SIGNATURE OF WITNESSES <i>John J. Smith</i>		36. SIGNATURE OF DECEASED <i>John J. Smith</i>	
37. SIGNATURE OF DECEASED <i>John J. Smith</i>		38. SIGNATURE OF WITNESSES <i>John J. Smith</i>		39. SIGNATURE OF DECEASED <i>John J. Smith</i>	
40. SIGNATURE OF DECEASED <i>John J. Smith</i>		41. SIGNATURE OF WITNESSES <i>John J. Smith</i>		42. SIGNATURE OF DECEASED <i>John J. Smith</i>	
43. SIGNATURE OF DECEASED <i>John J. Smith</i>		44. SIGNATURE OF WITNESSES <i>John J. Smith</i>		45. SIGNATURE OF DECEASED <i>John J. Smith</i>	
46. SIGNATURE OF DECEASED <i>John J. Smith</i>		47. SIGNATURE OF WITNESSES <i>John J. Smith</i>		48. SIGNATURE OF DECEASED <i>John J. Smith</i>	
49. SIGNATURE OF DECEASED <i>John J. Smith</i>		50. SIGNATURE OF WITNESSES <i>John J. Smith</i>		51. SIGNATURE OF DECEASED <i>John J. Smith</i>	
52. SIGNATURE OF DECEASED <i>John J. Smith</i>		53. SIGNATURE OF WITNESSES <i>John J. Smith</i>		54. SIGNATURE OF DECEASED <i>John J. Smith</i>	
55. SIGNATURE OF DECEASED <i>John J. Smith</i>		56. SIGNATURE OF WITNESSES <i>John J. Smith</i>		57. SIGNATURE OF DECEASED <i>John J. Smith</i>	
58. SIGNATURE OF DECEASED <i>John J. Smith</i>		59. SIGNATURE OF WITNESSES <i>John J. Smith</i>		60. SIGNATURE OF DECEASED <i>John J. Smith</i>	
61. SIGNATURE OF DECEASED <i>John J. Smith</i>		62. SIGNATURE OF WITNESSES <i>John J. Smith</i>		63. SIGNATURE OF DECEASED <i>John J. Smith</i>	
64. SIGNATURE OF DECEASED <i>John J. Smith</i>		65. SIGNATURE OF WITNESSES <i>John J. Smith</i>		66. SIGNATURE OF DECEASED <i>John J. Smith</i>	
67. SIGNATURE OF DECEASED <i>John J. Smith</i>		68. SIGNATURE OF WITNESSES <i>John J. Smith</i>		69. SIGNATURE OF DECEASED <i>John J. Smith</i>	
70. SIGNATURE OF DECEASED <i>John J. Smith</i>		71. SIGNATURE OF WITNESSES <i>John J. Smith</i>		72. SIGNATURE OF DECEASED <i>John J. Smith</i>	
73. SIGNATURE OF DECEASED <i>John J. Smith</i>		74. SIGNATURE OF WITNESSES <i>John J. Smith</i>		75. SIGNATURE OF DECEASED <i>John J. Smith</i>	
76. SIGNATURE OF DECEASED <i>John J. Smith</i>		77. SIGNATURE OF WITNESSES <i>John J. Smith</i>		78. SIGNATURE OF DECEASED <i>John J. Smith</i>	
79. SIGNATURE OF DECEASED <i>John J. Smith</i>		80. SIGNATURE OF WITNESSES <i>John J. Smith</i>		81. SIGNATURE OF DECEASED <i>John J. Smith</i>	
82. SIGNATURE OF DECEASED <i>John J. Smith</i>		83. SIGNATURE OF WITNESSES <i>John J. Smith</i>		84. SIGNATURE OF DECEASED <i>John J. Smith</i>	
85. SIGNATURE OF DECEASED <i>John J. Smith</i>		86. SIGNATURE OF WITNESSES <i>John J. Smith</i>		87. SIGNATURE OF DECEASED <i>John J. Smith</i>	
88. SIGNATURE OF DECEASED <i>John J. Smith</i>		89. SIGNATURE OF WITNESSES <i>John J. Smith</i>		90. SIGNATURE OF DECEASED <i>John J. Smith</i>	
91. SIGNATURE OF DECEASED <i>John J. Smith</i>		92. SIGNATURE OF WITNESSES <i>John J. Smith</i>		93. SIGNATURE OF DECEASED <i>John J. Smith</i>	
94. SIGNATURE OF DECEASED <i>John J. Smith</i>		95. SIGNATURE OF WITNESSES <i>John J. Smith</i>		96. SIGNATURE OF DECEASED <i>John J. Smith</i>	
97. SIGNATURE OF DECEASED <i>John J. Smith</i>		98. SIGNATURE OF WITNESSES <i>John J. Smith</i>		99. SIGNATURE OF DECEASED <i>John J. Smith</i>	
100. SIGNATURE OF DECEASED <i>John J. Smith</i>		101. SIGNATURE OF WITNESSES <i>John J. Smith</i>		102. SIGNATURE OF DECEASED <i>John J. Smith</i>	

BUREAU V. 5
AUG 29 1957

RECEIVED

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

08875

CERTIFICATE OF DEATH

Reg. Dist. No. 290

08887

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. LENGTH OF STAY IN 1b 50 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 303 Aurora St.				d. STREET ADDRESS 303 Aurora St.			
3. NAME OF DECEASED (Type or print) WILLIAM DAVID HILL				4. DATE OF DEATH Month Aug. Day 18, Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 20, 1898	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist		10b. KIND OF BUSINESS OR INDUSTRY Drug Store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? UsS.	
13. FATHER'S NAME Joseph C. Hill				14. MOTHER'S MAIDEN NAME Ida Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. 1 214-34-7337		17. INFORMANT Mrs. Marion Hill Address Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of breast 190x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Melanotic Carcinoma DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 yrs.						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 7, 1953 , to 8/18, 1957 , that I last saw the deceased alive on Aug 18, 1957 , and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton, Md. DATE SIGNED ACTUAL SIGNATURE M. V. Palmer M.D. PHYSICIAN'S NAME (Type) Dr. Virginia Palmer Easton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 21, 1957		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son ADDRESS Easton, Md.				24a. REC'D BY REGISTRAR DATE 8/21/57		24b. REGISTRAR'S SIGNATURE M. A. Neerney	

MASSACHUSETTS DEPARTMENT OF HEALTH—BALTIMORE 18

RECEIVED
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BUREAU V. 3

AUG 23 1957

BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08876

CERTIFICATE OF DEATH

08888

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>30 hrs 50 mins</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>R.F.D. #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Everett</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1895</u>	9. AGE (In years lost birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drugs</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oswald N. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Ella D. Casson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Elizabeth C. Jones</u> Address <u>R.D. #2 Easton</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-cranial Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Gastric ulcer</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u> </u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>8:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>219 S. Washington St. Easton 16, Maryland</u> <u>8 Aug 57</u>					
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		<u>Easton 16, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 9, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Korman & Son</u>				ADDRESS <u>Easton, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W.H. Newlin</u>	
DATE <u>8/5/57</u>				24b. REC'D BY REGISTRAR <u> </u>			

BUREAU V. 8

AUG 15 1957

RECEIVED

08877

CERTIFICATE OF DEATH

08889

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Rural Oxford.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hospital. Easton.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ernst David Frederick Christian Langberg		4. DATE OF DEATH Month Day Year Aug 16, 1957 19	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31, 1870
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant.		10b. KIND OF BUSINESS OR INDUSTRY Manager.	
11. BIRTHPLACE (State or foreign country) Rostock, Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Frederick Langberg.		14. MOTHER'S MAIDEN NAME Elizabeth Thiel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Paul V. Torek.		Address Oxford, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma DUE TO (c) Carcinoma of Prostate		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs 2 yrs 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 to 16 Aug , 19 57 , that I last saw the deceased alive on 16 Aug , 19 56 , and that death occurred at 8:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE J. Tyler Baker M.D.		ADDRESS Easton, Md	
PHYSICIAN'S NAME (Type) J. Tyler Baker			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF August 19	22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	22d. LOCATION (City, town, or county) (State) Middle Village, N. Y.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Necker 1957.		24a. REC'D BY REGISTRAR DATE 8/19/57	
ADDRESS Easton Md		24b. REGISTRAR'S SIGNATURE N. H. Necker	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 23 1957

RECEIVED

08885

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>		c. LENGTH OF STAY IN 1b <u>20 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle <u>L.</u> Last <u>McSTEEN</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 24 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	9. AGE (In years last birthday) <u>71</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>TALBOT CO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>BENJAMIN LAMBDIN</u>		14. MOTHER'S MAIDEN NAME <u>MARY SHERWOOD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Wm P. Harris, St. Michaels Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Dis</u> DUE TO (c) <u>10-15 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>auto</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:00 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. Lane Wirth</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Box 487, St. Michaels, Md 8-13-57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG 15, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROSEDALE CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>East ORANGE NEW JERSEY</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Hambleton Harrison, St Michaels</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 15 '57</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARY ANN		45		F		W		1880		BALTIMORE		MD		USA			
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY							
MARRIED		1900		BALTIMORE		MD		USA									
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		DEGREE		CITY		STATE		COUNTRY			
HIGH SCHOOL		BALTIMORE		MD		USA											
OCCUPATION		DATE		PLACE		CITY		STATE		COUNTRY							
Nurse		1900		BALTIMORE		MD		USA									
CAUSE OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY							
Heart failure		1925		BALTIMORE		MD		USA									
MANNER OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY							
Natural		1925		BALTIMORE		MD		USA									
CERTIFICATE OF DEATH		DATE		PLACE		CITY		STATE		COUNTRY							
1925		1925		BALTIMORE		MD		USA									
SIGNATURE OF DECEASED		DATE		PLACE		CITY		STATE		COUNTRY							
		1925		BALTIMORE		MD		USA									
SIGNATURE OF WITNESS		DATE		PLACE		CITY		STATE		COUNTRY							
		1925		BALTIMORE		MD		USA									
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		STATE		COUNTRY							
		1925		BALTIMORE		MD		USA									
SIGNATURE OF CLERK		DATE		PLACE		CITY		STATE		COUNTRY							
		1925		BALTIMORE		MD		USA									

BUREAU V. 1

AUG 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08878

CERTIFICATE OF DEATH

08891

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Jalbat</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Jalbat</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>4 hrs 53 min x 2</u> <u>Condoos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Monday</u>				4. DATE OF DEATH Month Day Year <u>8</u> <u>16</u> <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>B</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-16-57</u>	
9. AGE (In years lost birthday) yrs. <u>4</u>		IF UNDER 1 YEAR Months Days <u>4</u> <u>53</u>		IF UNDER 24 HRS. Hours Min <u>4</u> <u>53</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Calvin Miller</u>				14. MOTHER'S MAIDEN NAME <u>Emma Monday</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Emma Monday</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>760.5</u> <u>Intro A hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pro-1720xixy</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8-16</u> , 1957, to <u>8-16</u> , 1957, that I last saw the deceased alive on <u>8-16-57</u> , and that death occurred at <u>11:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>2195 Washington St. 17A957</u>			
DATE SIGNED <u>8/17/57</u>							
PHYSICIAN'S NAME (Type) <u>Ed Schmidt</u>				City or town, state <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Town Cmn</u>		22d. LOCATION (City, town, or county) (State) <u>Condoos, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Washelli, Easton, Md.</u>				24a. REC'D BY REGISTRAR <u>8/17/57</u>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <u>N.A. Neerix</u>			

2080383XVO

BUREAU V. S.

AUG 23 1957

RECEIVED

08879

CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 EASTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION S. HANSON ST.				d. STREET ADDRESS S. HANSON ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle NORMAN Last PARROTT				4. DATE OF DEATH Month AUGUST Day 29 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 5 1880		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM NICHOLAS PARROTT				14. MOTHER'S MAIDEN NAME SARAH CHOMEERS PARROTT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 213-229018		17. INFORMANT Address S. HANSON ST. EASTON, MD. Mrs. Carrie Parrott			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis DUE TO (c) General arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 5 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> Hour a. <input type="checkbox"/> p. m. <input type="checkbox"/> 19 <input type="checkbox"/>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1950 , 19 1957 , to 1957 that I last saw the deceased alive on 8/13/57 , 19 1957 , and that death occurred at Easton, Md. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. C. Cox				M.D. Easton, Md.			
PHYSICIAN'S NAME (Type) W. C. Cox							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/31/57		22c. NAME OF CEMETERY OR CREMATORY SPRING HILL CEMETERY		22d. LOCATION (City, town, or county) (State) EASTON MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Gandy				ADDRESS EASTON MD.		24a. RECD BY REGISTRAR SEP 6 1957	
				24b. REGISTRAR'S SIGNATURE M. A. Neuss			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER		REMARKS	
OCCUPATION		INDUSTRY		TRADE		PROFESSION		VOCATION		SPECIALTY		DEPARTMENT		DIVISION	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		GRADUATE		POSTGRADUATE		DEGREE		FIELD	
RELIGION		METHODIST		CATHOLIC		LUTHERAN		BAPTIST		PRESBYTERIAN		OTHER		REMARKS	
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER		REMARKS		REMARKS		REMARKS	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		REMARKS		REMARKS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER		SIGNATURE OF DEPUTY	
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE		REMARKS		REMARKS	

RECEIVED
SEP 6 1957
BUREAU V. 3

CERTIFICATE OF DEATH

Reg. Dist. No.

08893

290

08880

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 381 Glebe Road				d. STREET ADDRESS 381 Glebe Road			
3. NAME OF DECEASED (Type or print) First GEORGE Middle WESLEY Last PRITCHARD				4. DATE OF DEATH Month Aug. 23, Day 19 Year 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1873		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Richard H. Pritchard				14. MOTHER'S MAIDEN NAME Louise Craft			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-01-8629A		17. INFORMANT Mrs. George W. Pritchard		Address Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JUNE 1957 to AUG. 23 1957 , that I last saw the deceased alive on AUG. 23 1957 , and that death occurred at 10:50 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald F. Bartley				ADDRESS (Street, city or town, state) 9 N. HANSON ST. Easton, Md.		DATE SIGNED 8-26-57	
PHYSICIAN'S NAME (Type) Dr. Donald F. Bartley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son				ADDRESS Easton, Md.		24a. REC'D. BY REGISTRAR DATE 8/26/57	
				24b. REGISTRAR'S SIGNATURE M. E. Newnam			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1912		Baltimore, Md.		Baltimore, Md.		Heart Disease		Aug 28, 1957		10:00 AM		Home		J. Smith, M.D.		A. Jones, Registrar	
Occupation		Marital Status		Education		Religion		Race		Color		Previous Illnesses		Alcohol Consumption		Tobacco Use		Drugs Used		Mental Status		Other Remarks	
Teacher		Married		High School		Catholic		White		White		Hypertension		Occasional		Daily		None		Normal			
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Toxicologist		Signature of Forensic Anthropologist		Signature of Forensic Entomologist		Signature of Forensic Radiologist		Signature of Forensic Chemist	

BUREAU V. H.

AUG 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

08881

CERTIFICATE OF DEATH

08894

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>Dalhart</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN 1b <u>3 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u> <u>05X22</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Robinson</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-1897</u>	
9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Estella Higgins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Dr. J. H. Huggins</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombosis, of coronary artery</u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>8-15-1957</u> , to <u>8-18-1957</u> , that I last saw the deceased alive on <u>8-18-1957</u> , and that death occurred at <u>3:05 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>219 S. Washington St</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				DATE SIGNED <u>18 Aug 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Greenlawn Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Bouclair</u>				ADDRESS <u>Greenlawn, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8/21/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>N. H. Newkirk</u>			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CORONA		c. LENGTH OF STAY IN 1b 9 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 CORONA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MAIN ST.			d. STREET ADDRESS 1 MAIN ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MICHAEL Middle JOHN Last SAXON			4. DATE OF DEATH Month AUG. Day 9 Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 20, 1897	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) MASS.	
13. FATHER'S NAME JOHN SAXON			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-14-0263		17. INFORMANT Address MRS. AGNES SAXON, CORONA, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X DUE TO Unicellular fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitral stenosis DUE TO chron. (c) Rheumatic carditis DUE TO chron.					INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 7 , 19 57 , to Aug 9 , 19 57 , that I last saw the deceased alive on Aug. 7 , and that death occurred at 2:30 M., from the causes and on the date stated above.					
ACTUAL SIGNATURE Kurt Lederer		M.D.		ADDRESS (Street, city or town, state) 8-10-57	
PHYSICIAN'S NAME (Type) KURT LEDERER		QUEEN ANNE		MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/12/57		22c. NAME OF CEMETERY OR CREMATORY SPRING HILL CEMETERY	
				22d. LOCATION (City, town, or county) (State) EASTON MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Gandy		ADDRESS EASTON, MD.		24a. REC'D BY REGISTRAR DATE 8/12/57	
				24b. REGISTRAR'S SIGNATURE N. D. Nevins	

CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Form No. 10

BUREAU V. 2

JUN 21 1957

RECEIVED

1. NAME OF DECEASED <i>John J. Lee</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>June 18, 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Chicago, Ill.</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. DATE OF MARRIAGE <i>1935</i>	
13. NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		14. NAME OF FUNERAL HOME <i>Green Valley</i>		15. NAME OF BURIAL PLACE <i>Green Valley</i>	
16. SIGNATURE OF DECEASED <i>John J. Lee</i>		17. SIGNATURE OF WITNESS <i>John J. Lee</i>		18. SIGNATURE OF DECEASED <i>John J. Lee</i>	
19. SIGNATURE OF DECEASED <i>John J. Lee</i>		20. SIGNATURE OF DECEASED <i>John J. Lee</i>		21. SIGNATURE OF DECEASED <i>John J. Lee</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shows, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

088896

08887

CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 119 South Higgin St.				d. STREET ADDRESS 119 Higgins			
3. NAME OF DECEASED (Type or print) First James Middle Benjamin Last D. Smith				4. DATE OF DEATH Month 8 Day 11 Year 1957			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/30/84	
9. AGE (In years last birthday) 72 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Brick Yard		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John W. Smith			
14. MOTHER'S MAIDEN NAME Sarah E. Butler				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XXX (If yes, give year or dates of service) XXXXX			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Annie Roberts, Easton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO years (c) years				INTERVAL BETWEEN ONSET AND DEATH years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-1 , 19 57 , to 8-11 , 19 57 , that I last saw the deceased alive on 8-10 , 19 57 , and that death occurred at 7 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. F. Buell				ADDRESS (Street, city or town, state) Easton, Md.			
DATE SIGNED 8-16-57				DATE SIGNED 8-16-57			
PHYSICIAN'S NAME (Type)				24a. REC'D BY REGISTRAR AUG 22 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8/17/57		22c. NAME OF CEMETERY OR CREMATORY Richards Cemetery	
22d. LOCATION (City, town, or county) (State) Easton Maryland				24b. REGISTRAR'S SIGNATURE N. H. Norris			
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell, Easton, Md.				ADDRESS			

BUREAU V. 3

AUG 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

08888

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09903

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton Rt. 2		c. LENGTH OF STAY IN lb LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton Rt. 2 X/			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Levin Middle L. Last Smith				4. DATE OF DEATH Month 8 Day 19 Year 1957			
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/18/71		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gustvus Smith				14. MOTHER'S MAIDEN NAME Rachael Tilghman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Rachael Lee Easton, md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4 years DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Lewis Welch				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) INELTY				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/57		22c. NAME OF CEMETERY OR CREMATORY Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Easton rt. 2 Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell				24a. REC'D BY REGISTRAR SEP 10 1957 DATE			
				24b. REGISTRAR'S SIGNATURE Mrs. D. H. Hennessey			

DATE SIGNED

8-70-57

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 sh. and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

088839

Item 9 Film 219 8-29-57 et

CERTIFICATE OF DEATH

08897

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>				c. LENGTH OF STAY IN 1b <u>3 wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Rio Vista Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>NORMAN</u> Last <u>STEWART</u>				4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 5, 1892</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>TALBOT Cty, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>WALTER PERRY</u>		14. MOTHER'S MAIDEN NAME <u>BERTRUDE COX</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Mrs. John Stewart</u>		Address <u>St. Michaels, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> 502.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema - severe</u> DUE TO (c) <u>Bronchitis - severe</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cachexia, generalized</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>7-16</u> , 19 <u>52</u> to <u>8-20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-20</u> , 19 <u>57</u> , and that death occurred at <u>1:45</u> AM, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Wm. M. Reese</u>		M.D. <u>St. Michaels Md</u>		ADDRESS (Street, city or town, state) <u>St. Michaels Md</u>		DATE SIGNED <u>8-20-57</u>	
PHYSICIAN'S NAME (Type) <u>Wm. M. Reese</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug. 22, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u>	
22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman D. Marshall</u>		ADDRESS <u>St. Michaels, Md.</u>		24a. REC'D BY REGISTRAR <u>26 57</u>	
24b. REGISTRAR'S SIGNATURE <u>W. M. Reese</u>							

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. RACE [Faint text]</p>	
<p>5. DATE OF DEATH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. CAUSE OF DEATH [Faint text]</p>		<p>8. MANNER OF DEATH [Faint text]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>10. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>11. SIGNATURE OF WITNESS [Faint text]</p>		<p>12. SIGNATURE OF DECEASED [Faint text]</p>	
<p>13. SIGNATURE OF NEXT OF KIN [Faint text]</p>		<p>14. SIGNATURE OF BURIAL SOCIETY [Faint text]</p>	
<p>15. SIGNATURE OF CHURCH [Faint text]</p>		<p>16. SIGNATURE OF FUNERAL HOME [Faint text]</p>	
<p>17. SIGNATURE OF CEMETERY [Faint text]</p>		<p>18. SIGNATURE OF OTHER [Faint text]</p>	

BUREAU V. S.

AUG 26 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G220 9-25-57 et

08898

08890

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY TALBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLAIBORNE				c. LENGTH OF STAY IN 1b 50 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last John O. TUNIS				4. DATE OF DEATH Month Day Year AUG 1 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1880 JULY 24 1879	
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supervisor		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOSEPH T. TUNIS				14. MOTHER'S MAIDEN NAME HELEN D. KEMP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address John O. Tunis Jr. WILMINGTON, DEL.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Heart Dis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH. 45 min 100h	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-21-1957 to 8-1-1957 , that I last saw the deceased alive on 8-1-1957 , and that death occurred at 12:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. H. White				ADDRESS (Street, city or town, state) DATE SIGNED Box 487, St. Michaels, Md 8-1-57			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG 3, 1957		22c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY		22d. LOCATION (City, town, or county) (State) SALISBURY MD	
23. FUNERAL DIRECTOR'S SIGNATURE L. Hamilton Harrison				ADDRESS St. Michaels Md		24a. REC'D BY REGISTRAR AUG 5 57	
				24b. REGISTRAR'S SIGNATURE R. H. White			

1957 5 5

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08882

CERTIFICATE OF DEATH

08899

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <i>Talbot Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Case Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fresh</i>		c. LENGTH OF STAY IN 1b <i>6 Days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Martina</i> Middle <i>Lucina</i> Last		4. DATE OF DEATH Month <i>8</i> Day <i>18</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-20-1890</i>
9. AGE (In years lost birthday) <i>67</i> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Med.</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Turner</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Jennings</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Mrs. J. W. Taylor</i>		Address <i>Sister</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral aneurysm</i> <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>(?)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/18/57</i> , 19 <i>57</i> , to <i>8/18</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>8/18/57</i> , 19 <i>57</i> , and that death occurred at <i>4:20 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thorston Harrison</i>		DATE SIGNED <i>8/22/57</i>	
PHYSICIAN'S NAME (Type) <i>THORSTON HARRISON</i>		ADDRESS (Street, city or town, state) <i>Chester, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-20-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Federalsburg, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harry Williams</i>		ADDRESS <i>Federalsburg, Md.</i>	
24a. REC'D BY REGISTRAR <i>8/22/57</i>		24b. REGISTRAR'S SIGNATURE <i>N. H. Newlin</i>	

BUREAU V. 8

AUG 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08900

08883

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SONIA</u> Middle <u>MARIE</u> Last <u>TURNER</u>				4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH, <u>Dec. 2, 1949</u>	
9. AGE (In years last birthday) <u>7</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAMES R. TURNER</u>		14. MOTHER'S MAIDEN NAME <u>JOAN V. TURNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Father</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Rheumatic myocarditis</u> <u>401.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. 11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>2195 Washington ST</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				DATE SIGNED <u>24 Aug 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carmichael Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Hill</u>				ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>9/26/57</u>	
24b. REGISTRAR'S SIGNATURE <u>N.H. Nevers</u>							

BUREAU A. S.

AUG 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08901
290

08884

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>		d. STREET ADDRESS <u>17X2.2</u>	
3. NAME OF DECEASED First <u>Ruby</u> Middle <u>J</u> Last <u>Walbert</u>		4. DATE OF DEATH Month <u>8</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-24-1897</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>8</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Franklin Jewell</u>		14. MOTHER'S MAIDEN NAME <u>Mary E Merchant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Theodore Walbert (husband) same</u>	
17. INFORMANT Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>4-20-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral cerebral thrombosis. Essential hypertension.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u>5</u> p. m. Month <u>19</u> Day <u>19</u> Year <u>1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4 Aug</u> , 19 <u>57</u> , to <u>8 Aug</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8 Aug</u> , 19 <u>57</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.		ADDRESS (Street, city or town, state) <u>Church Hill, Md</u> DATE SIGNED <u>9 Aug 57</u>	
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sudlersville</u>		22d. LOCATION (City, town, or county) (State) <u>Sudlersville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill, Md</u>		24a. REC'D BY REGISTRAR <u>N.H. Neer</u> DATE <u>8/10/57</u>	
24b. REGISTRAR'S SIGNATURE			

may be received by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08902

08891

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CORDOVA</u>			c. LENGTH OF STAY IN 1b <u>7 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 CORDOVA</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CORDOVA (home)</u>				d. STREET ADDRESS <u>MATTHEWS TOWN ROAD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY</u> <u>ZIEGLER</u>				4. DATE OF DEATH Month Day Year <u>August</u> <u>31</u> <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 23, 1879</u> 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Shippack Township, Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>Abraham V. Hunsburger</u>				14. MOTHER'S MAIDEN NAME <u>HANNA B. Hunsburger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>818-20-4200A</u>		17. INFORMANT <u>HARRY H. ZIEGLER</u> Address <u>CORDOVA</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>CORONARY INFARCTION</u> DUE TO (c) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>August 22, 1957</u> , to <u>August 31, 1957</u> , that I last saw the deceased alive on <u>August 23, 1957</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ludwig J. Eglseder M.D.</u>				ADDRESS (Street, city or town, state) <u>12 N. HANSON ST. August 31, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Ludwig J. Eglseder</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept. 4, 1957</u>		<u>Fairview</u>		<u>Near Cordova Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Hugh Moore</u>				24a. REC'D BY REGISTRAR DATE <u>9/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Neerick</u>	

RECEIVED